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5. a. Return on Equity - Return on equity will be limited to the equity of the facility's owner when determining allowable lease expense. Return on equity will be limited to 10%. For the purpose of determining allowable lease expense, equity will be computed in accordance with PRM-15 principles. The allowable base will be determined by monthly averaging of the annual equity balances. The base will be increased by the amount of paid up principal in a period but will be reduced by depreciation expense in that period.

b. Item 398D of the 1987 Appropriations Act (as amended), effective April 8, 1987 eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

§2.1. Leases approved prior to August 18, 1975.

A. Leases approved prior to August 18, 1975, shall have the terms of those leases honored for reimbursement throughout the duration of the lease.

B. Renewals and extensions to these leases shall be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses shall be approved.

C. Payments of rental costs for leases reimbursed pursuant to §2.1.A. above shall be allowed whether the provider occupies the premises as a lessee, sublessee, assignee, or otherwise. Regardless of the terms of any present or future document creating a provider's tenancy or right of possession, and regardless of whether the terms thereof or the parties thereto may change from time to time, future reimbursement shall be limited to the lesser of (1) the amount actually paid by the provider, or (2) the amount reimbursable by DMAS under these regulations as of the effective date this amendment. In the event extensions or renewals are approved pursuant to subsection B of this section, no escalation clauses shall be approved or honored for reimbursement purposes.

§3.1. Nothing in this Section shall be construed as assuring providers that reimbursement for rental costs will continue to be reimbursable under any further revisions of or amendment to these regulations.

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APPENDIX III

COST REIMBURSEMENT LIMITATIONS

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§1.1. Foreword.

A. The attached information outlines operating, NATCEPs and plant cost limitations that are not referenced in previous sections of these regulations.

B. All of the operating cost limitations are further subject to the applicable operating ceilings.

§1.2. Fees.

A. Directors' Fees.

1. Although Medicaid does not require a board of directors (Medicare requires only an annual stockholders' meeting), the Program will recognize reasonable costs for directors' meetings related to patient care.

2. It is not the intent of DMAS to reimburse a facility for the conduct of business related to owner's investments, nor is it the intent of the Program to recognize such costs in a closely held corporation where one person owns all stock, maintains all control, and approves all decisions.

3. To receive reimbursement for directors' meetings, the written minutes must reflect the name of the facility for which the meeting is called, the content and purpose of the meeting, members in attendance, the time the meeting began and ended, and the date. If multiple facilities are discussed during a meeting, total allowable director fees, as limited herein, shall be pro-rated between such facilities.

4. Bona fide directors may be paid an hourly rate of $125 up to a maximum of four (4) hours per month. These fees include reimbursement for time, travel, and services performed.

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5. Compensation to owner/administrators who also serve as directors, shall include any and director's fees paid, subject to the above referenced limit those set forth in these regulations.

B. Membership Fees.

1. These allowable costs will be restricted to membership in health care organizations and appropriate professional societies which promote objectives in the provider's field of health care activities.

2. Membership fees in health care organizations and appropriate professional societies will be allowed for the administrator, owner, and home office personnel.

3. Comparisons will be made with other providers to determine reasonableness of the number of organizations to which the provider will be reimbursed for such membership and the claimed costs, if deemed necessary.

C. Management Fees.

1. External management services shall only be reimbursed if they are necessary, cost effective, and non-duplicative of existing NF internal management services.

2. Costs to the provider, based upon a percentage of net and/or gross revenues or other variations thereof, shall not be an acceptable basis for reimbursement. If allowed, management fees must be reasonable and based upon rates related to services provided.

3. Management fees paid to a related party may be recognized by the Program as the owner's compensation subject to administrator compensation guidelines.

4. A management fees service agreements exists when the contractor provides non-duplicative personnel, equipment, services, and supervision.

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5. A consulting service agreement exists when the contractor provides non-duplicative supervisory or management services only.

6. Limits will be based upon comparisons with other similar size facilities and/or other DMAS guidelines and information.

Effective for all providers' cost reporting periods ending on or after October 1, 1990, a per patient day ceiling for all full service management service costs shall be established. The ceiling limitation for cost reporting periods ending on or after October 1, 1990, through December 31, 1990, shall be the median per patient day cost as determined from information contained in the most recent cost reports for all providers with fiscal years ending through December 31, 1989. These limits will be adjusted annually by a Consumer Price Index effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually.

D. Pharmacy Consultants Fees. Costs will be allowed to the extent they are reasonable and necessary.

E. Physical Therapy Fees. (For outside services.) Limits are based upon current PRM-15 guidelines.

F. Inhalation Therapy Fees. (For outside services.) Limits are based upon current PRM-15 guidelines.

G. Medical Directors' Fees. Costs will be allowed up to the established limit per year to the extent that such fees are determined to be reasonable and proper. This limit will be escalated annually by the CPI-U January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. The following limitations apply to the time periods as indicated:

Jan. 1, 1988 - Dec. 31, 1988 $6,204
Jan. 1, 1989 - Dec. 31, 1989 $6,625

H. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

§1.3. Personal Automobile.

A. Use of personal automobiles when related to patient care will be reimbursed at the maximum of the allowable IRS mileage rate when travel is documented.

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§1.4. Seminar expenses.

These expenses will be treated as allowable costs, if the following criteria are met:

A. Seminar must be related to patient care activities, rather than promoting the interest of the owner or organization.

B. Expenses must be supported by:

1. Seminar brochure,

2. Receipts for room, board, travel, registration, and educational material.

C. Only the cost of two persons per facility will be accepted as an allowable cost for seminars which involve room, board, and travel.

§1.5. Legal retainer fees.

DMAS will recognize legal retainer fees if such fees do not exceed the following:

BED SIZE	LIMITATIONS
0 - 50	$100.00 per month
51 - 100	$150.00 per month
101 - 200	$200.00 per month
201 - 300	$300.00 per month
301 - 400	$400.00 per month

The expense to be allowed by DMAS shall be supported by an invoice and evidence of payment.

§1.6. Architect fees.

Architect fees will be limited to the amounts and standards as published by the Virginia Department of General Services.

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§1.7 Administrator/owner compensation.

DMAS ADMINISTRATOR/OWNER COMPENSATION SCHEDULE
JANUARY 1, 1989 - DECEMBER 31, 1989

BED SIZE	NORMAL ALLOWABLE FOR ONE ADMINISTRATOR	MAXIMUM FOR 2 OR MORE ADMINISTRATORS
1 - 75	32,708	49,063
76 - 100	35,470	53,201
101 - 125	40,788	61,181
126 - 150	46,107	69,160
151 - 175	51,623	77,436
176 - 200	56,946	85,415
201 - 225	60,936	91,399
226 - 250	64,924	97,388
251 - 275	68,915	103,370
276 - 300	72,906	108,375
301 - 325	76,894	115,344
326 - 350	80,885	121,330
351 - 375	84,929	127,394
376 & over	89,175	133,763

These limits will be escalated annually by the CPI-U effective January 1 of each calendar year to be effective for all provider's cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually.

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§1.8 Kinetic Therapy

For specialized care reimbursement effective December 2, 1996, a limitation per patient day on kinetic therapy shall be established based on historical data*. This limit shall be reviewed annually by January 1 of each calendar year, and compared to actual cost data, then revised if appropriate, to be effective for all providers' cost reporting periods ending on or after that date. The limit will be published and distributed to providers annually. It shall be:

December 1, 1996 - December 31, 1997	$102.00 per day

*NOTE: DMAS will gather data over time from provider cost reports, supplemented from other industry sources, on prices of kinetic therapy equipment. From this data DMAS will develop a trend factor to be applied to the base amount.

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APPENDIX IV

CLASS RESOURCE COST ASSIGNMENT,
COMPUTATION OF SERVICE INTENSITY INDEX AND
CEILING AND RATE ADJUSTMENTS TO THE PROSPECTIVE
DIRECT PATIENT CARE OPERATING COST RATE

ALLOWANCE FOR INFLATION METHODOLOGY
BASE "CURRENT" OPERATING RATE